



Human Resources Department

16000 N. Civic Center Plaza

Surprise, AZ 85374

Office: 623-222-3500

Fax: 623-222-3501

TTY: 623-222-1022

EMPLOYEE REQUEST FOR AN ACCOMMODATION

Please note that this information will be maintained in a separate confidential file from your personnel file and will be limited only to those with a need-to-know.

Today's Date: _____ Date of Verbal Request: _____

Employee Name: _____ Phone Number: _____

Job Title: _____ Department: _____

Immediate Supervisor: _____

What type of accommodation are you requesting?

- | | | |
|--|--|--|
| <input type="checkbox"/> Modified work schedule | <input type="checkbox"/> Removal of communications barrier | <input type="checkbox"/> Job restructuring |
| <input type="checkbox"/> Change in procedure | <input type="checkbox"/> Purchase of assistive services | <input type="checkbox"/> Reassignment |
| <input type="checkbox"/> Purchase assistive device | <input type="checkbox"/> Removal of architectural barrier | <input type="checkbox"/> Other: _____ |

Describe the suggested accommodation: _____

Explain how the accommodation will enable performance of essential functions of position: _____

Please check those major life activities you believe to be limited by your medical condition(s):

- | | | | | |
|----------------------------------|----------------------------------|------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Talking | <input type="checkbox"/> Breathing | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Seeing |
| <input type="checkbox"/> Working | <input type="checkbox"/> Hearing | <input type="checkbox"/> Learning | <input type="checkbox"/> Caring for Oneself | <input type="checkbox"/> Other: _____ |

Please describe how the above activities are limited: _____

Is medical condition temporary: ☐ Yes ☐ No

If yes, please state the expected duration: _____

Please provide us with the name of your healthcare provider(s) who can assist in this request. If you have additional providers who also have information on this matter, please list that information on a separate sheet:

Provider's Name: _____ Phone: _____

Address: _____

Provider's Name: _____ Phone: _____

Address: _____

Have you applied for a reasonable accommodation previously with the City: ☐ Yes ☐ No

If yes, please explain the status and/or circumstances: _____

It is the policy of the City of Surprise to provide reasonable accommodations to qualified individuals with disabilities in accordance with the Americans with Disabilities Act. I understand that a detailed review of my disability status will be required and I agree to cooperate fully in this process. I understand that if my request is granted, I am obligated to report any changes in my disability status which may require a reevaluation of this request. I further understand that the accommodation requested above may not be granted but that the City will attempt to provide a reasonable accommodation that does not create an undue hardship on the City's business. Granting this request does not signify approval of any future reasonable accommodation request for any other position within this department or any other department within the City

Employee's Signature: _____ Date: _____

**RETURN COMPLETED FORM TO
HUMAN RESOURCES IMMEDIATELY**